NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Patient Name: ______________________________

Address: ___________________________________

City: ________________ State: ____ Zip: ________

DOB: ______________________________________

SSN: ______________________________________

Your signature below indicates that you have been offered a copy of Southwest Pediatric Orthopedics Notice of Privacy Practices.

I have been offered the Notice of Privacy Practices.

Legal Guardian or
Patient Representative
Signature: ___________________________________ Date: ______________

Printed Legal Guardian or
Patient Representative
Name: _______________________________________ Date: ______________

Relationship to Patient: _______________________ Date: ______________

FOR OFFICE USE ONLY:
Southwest Pediatric Orthopedics will make a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices provided to the patient. If the patient is unwilling or unable to sign this acknowledgment, Southwest Pediatric Orthopedics must document its good faith efforts to obtain such acknowledgments and record the reason why the acknowledgment was not obtained.

Reason: ____

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